Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN333AGC	A. BUILDING _____ B. WING _____	C 08/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES CT RENO, NV 89503

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Y 000	Initial Comments This Statement of Deficiencies was generated as a result of a Complaint Investigation initiated in your facility on 6/27/08 and completed on 8/8/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. Complaint #NV00018584 was substantiated with deficiencies.	Y 000		
Y 590 SS=H	449.268(1)(a) Resident Rights NAC 449.268 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by: Based on record reviews and interviews from 6/27/08 to 8/8/08, the facility did not ensure 15 of 45 residents received their medications as prescribed by their physician. Findings include: An annual survey was conducted at the facility between 5/6/08 to 5/15/08. The facility was cited during the annual survey for failure to ensure medications prescribed to residents were available at the facility. The facility indicated on their Plan of Correction, submitted on 6/9/08, that	Y 590		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 590	Continued From page 1 a medication auditing system had been implemented on 5/16/08 to ensure resident medications were being re-ordered, delivered and available at the facility. During the complaint investigation initiated on 6/27/08, it was found that after the program had been implemented, the facility still did not ensure medications were available at the facility for administration to the following residents in June 2008. Resident #1: - Morphine Sulfate ER 15 mg tablets, two times a day. The resident missed two doses on 6/4/08. - Oxycodone APAP 5/325 mg tablets, every four hours while awake was listed on the resident's medication administration records (MARs) to be given at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. From 6/13/08 to 6/16/08, the resident did not receive 11 out of 16 doses. Resident #4: - Norvasc 5 mg, one time a day. The resident did not receive the medication on 6/2/08 and 6/4/08. - Catapres Patch 0.2 mg/24, one patch weekly. The facility documented the patch had not applied for three weeks (6/12/08, 6/19/08, and 6/26/08) because the facility did not have them available. Resident #7: - Prilosec OTC 20 mg, two times a day 30 minutes before meals. The resident missed eight doses from 6/13/08 to 6/16/08. - Mylanta Liquid, two tablespoons before meals and at bedtime. The resident missed nine out of fourteen doses from 6/18/08 to 6/25/08. Resident #9: - Furosemide 80 mg, two 40 mg tablets every	Y 590		

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Y 590	Continued From page 2	Y 590		

day. The resident missed one dose on 6/27/08, the day of the investigation.
- Diltiazem ER 240 mg, one every day. The resident missed five doses from 6/23/08 to 6/27/08. Two pills were found in the facility's office by the administrator and documentation showed the medication had been last filled on 5/21/08.
- Lanoxin 0.125 mg, one every day. The resident missed five doses from 6/25/08 to 6/27/08. The administrator determined the medication was filled on 6/10/08 and could not explain why the resident would not have received the medication.

Resident #13:
- Folic Acid 1.0 mg, one time a day. The resident missed four doses from 6/21/08 to 6/24/08.
- Famotidine 20 mg, two times a day. The resident missed six doses from 5:00 PM on 6/20/08 through 8:00 AM on 6/24/08.
- Centrum Silver and Vitamin C 500 mg, one time a day. The resident missed four doses from 6/21/08 to 6/24/08.
- Hydrocodone/APAP 5/500 mg, four times a day. The resident missed three doses from 6/12/08 to 6/13/08.

Resident #14:
- Ibuprofen 200 mg, three times a day. The resident missed 10 doses between 5:00 PM 6/17/08 through 5:00 PM 6/20/08.

Resident #15:
- Actos 15 mg, one time a day. The resident missed two doses between 6/5/08 to 6/6/08.
- Synthroid 50 mcg, one time a day. The resident missed one dose on 6/3/08.
- Lantus Insulin 35 units daily in the morning. The resident missed one dose on 6/13/08.
- Simvastatin 40 mg, one at bedtime. The

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resident missed two doses from 6/7/08 to 6/8/08.
- Fosamax 70 mg, one tablet weekly. The resident missed three weekly doses from 6/12/08 to 6/26/08.
- Calcium D 600 mg. The resident missed three doses between 6/14/08 to 6/25/08.

A second visit was conducted on 7/18/08 and based on medication record reviews, the facility did not ensure the following residents were provided with all their medications in July 2008:

Resident #1:
- Morphine Sulfate ER 15 mg tablets two times a day. From 8:00 PM on 7/4/08 to 8:00 AM 7/7/08, the resident missed six out of eight doses. The facility documented in their Quality Assurance (QA) notes they called in a re-fill order to the pharmacy on Tuesday, 7/1/08 and had six doses of the medication to last through the morning of Friday, 7/4/08. The pharmacy reported to the facility they did not receive a refill order from the resident's physician until Monday, 7/7/08. The administrator reported the resident's family was very upset to see the resident in pain over the holiday.
- Effexor XR 75 mg tablets, one tablet a day. The resident missed two doses from 7 /13/08 to 7/14/08. The facility documented they called the pharmacy for a re-fill on 7/8/08 and had five doses left that should have lasted through 7/13/08. The pharmacy reported on 7/10/08 they were waiting for a physician's order and the medication was delivered on 7/14/08.

Resident #2:
- Felodipine ER 2.5 mg tablet, one time a day. The resident missed three doses from 7/16/08 to 7/18/08. The facility's QA notes indicated a re-fill was ordered on 7/8/08 with eight doses left and

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Y 590	Continued From page 4 the medication was ordered again on 7/16/08 because the resident was out of medication. Resident #3: - Mag Trisol 1000 mg, four 250 mg tablets two times a day. The resident did not receive the medication at 8:00 PM on 7/13/08 and at 8:00 AM on 7/14/08. The facility's QA notes indicated a re-fill was ordered on 7/8/08 with 24 doses left. Resident #4: - Catapres Patch 0.2 mg/24, one patch weekly. The facility documented the patch had not applied for one week (7/4/08) because the facility did not have them available. The resident went without the patches for a total of four weeks before they were re-ordered on 7/7/08 by the facility. - Lisinopril 20 mg, one time a day. The resident did not received four doses from 7/4/08 through 7/7/08. The medication was ordered on 6/24/08 with nine doses left and reordered on 7/7/08 after the resident was not given the medication for four days. The medication was delivered on 7/9/08. Resident #5: - Lexapro 10 mg, two times a day. The resident did not receive six doses from 7/1/08 through 7/3/08. The medication was ordered on 6/30/08 and delivered on 7/4/08. Resident #6: - Xanax 0.25 mg, two times a day. The facility documented that the resident did not receive the 8:00 PM doses on 7/4/08, 7/5/08 and 7/6/08; but the 8:00 AM doses were documented as given on 7/5/08, 7/6/08 and 7/7/08. The facility was unable to determine why this occurred. Resident #7: - Prilosec OTC 20 mg, two times a day 30	Y 590		

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Y 590	Continued From page 5 minutes before meals. The resident did not receive five doses between 7/16/08 and 7/18/08. - Accolate 20 mg, 1/2 tablet, two times a day. The resident did not received the 8:00 AM dose on 7/14/08 and 7/15/08 and the 5:00 PM dose on 7/15/08. The facility documented the resident had a doctor's appointment on 7/9/08 and the family wanted to see if the medication would be discontinued. The medication was not discontinued by the doctor and the facility did not reorder the medication until 7/15/08. - Methadone 10 mg, two tablets every eight hours. The resident missed nine doses between 12:00 PM on 7/15/08 to 4:00 AM on 7/18/08. The facility documented the medication was reordered on 7/15/08 with six tablets left. Resident #8: - Xanax 0.25 mg, 1/2 tablet two times a day. It was documented that the resident did not receive the 8:00 AM doses on 7/3/08 and 7/5/08; and the 8:00 PM doses on 7/3/08, 7/4/08 and 7/5/08. The resident also had a second order of Xanax 0.25 mg, 1/2 tablet as needed (PRN) every four hours for agitation. The PRN medication card showed the resident received 8:00 AM doses on the on 7/3/08 and 7/5/08. The administrator stated she believed the medication was available but the caregivers were interchanging the two medication cards based on a comparison of the dates initialed on the medication cards to the MARs. The caregivers were inconsistent in documenting the dates and times the resident received PRN medications. - Lexapro 10 mg, one time a day. The resident did not receive two doses of the medication from 7/9/08 to 7/10/08. Resident #9: - Prilosec OTC 20 mg, one time a day. The	Y 590		

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Y 590	Continued From page 6 resident did not receive the medication for 13 days from 7/1/08 to 7/13/08. Resident #10: - Potassium CL 20 meq, three times a day. The resident did not receive the 12:00 PM and 5:00 PM doses on 7/17/08. Resident #11: - Calcium/Magnesium/Zinc supplement, three times a day. The resident did not receive 54 doses of the medication from 7/1/08 to 7/18/08. Resident #12: - Norvasc 5 mg, two times a day. The resident did not receive the 8:00 AM dose on 7/8/08. This is a repeat deficiency from the annual survey dated 5/6/08 to 5/15/08. Severity: 3 Scope: 2	Y 590		